PERSON WITH A DISABILITY PARKING PERMIT APPLICATION

STATE OF HAWAII
DISABILITY AND COMMUNICATION ACCESS BOARD

See the Instruction Sheet for assistance in completing this form. Please print or type.

IMPORTANT: Applicant must complete this side of form. Physician must complete reverse side. Application may be disapproved if not fully completed on both sides. Application must be submitted by the applicant to the appropriate county agency within 60 days of the physician's certification. Applications processed until 3:00 p.m., M-F. Original signatures are required.

Applicant must present proof of identity. All forms of identification must be current or unexpired. Acceptable forms of photo identification include: drivers license, state ID, passport, senior citizen ID, military ID, student ID, ID of a parent or guardian of a minor. Acceptable forms of non-photo identification include: Social Security card; Medicare card; notarized affidavit from: a Hawaii State or county social service agency, the administrator of a Hawaii State or privately owned nursing home, the spouse, an adult relative, a friend, an assistant, or the verifying physician.

FOR OFFICIAL USE ONLY

1st Placard # _____

2nd Placard # _____

Expiration Date _____

License Plates # _____

FEES COLLECTED, IF APPLICABLE:

Amount Collected: $_____

✗_____
Clerk's Initials Date

1. APPLICANT'S NAME

_____ _____ _____
LAST FIRST M.I.

2. IDENTIFICATION (Circle one) HI DL / HI ID / HI Tax Cert. / Mil ID / Other ID (Specify) _____

Identification No. _____

3. TELEPHONE NO. _____ **4. BIRTH DATE** _____ / _____ / _____
(00 / 00 / 0000) MONTH DAY YEAR

5. HEIGHT _____ / _____ **6. WEIGHT** _____ **7. GENDER** ❑ Male ❑ Female
FEET INCHES POUNDS

8. STREET ADDRESS

_____
STREET APT.# CITY ZIP CODE

9. MAILING ADDRESS **(Not required if same as #8)**

_____
STREET/ P.O. BOX APT.# CITY ZIP CODE

10. IF YOU LIVE IN HAWAII Only if you live in Hawaii, indicate the county where you live by marking the applicable box.

❑ C & C of Honolulu ❑ County of Hawaii ❑ County of Kauai ❑ County of Maui

11. PARKING PLACARD REQUEST Mark applicable box(es) and enter serial number of placard(s) last issued. I am applying for:

❑ A **First** Time Hawaii placard.

❑ A **Second** Hawaii placard. Last issued placard #_____ (If applicable)

❑ A **Renewal** of my Hawaii placard(s). Last issued placard #(s)_____

❑ A Replacement of my **Lost** Hawaii placard. Last issued placard #(s)_____

❑ A Replacement of my **Mutilated** Hawaii placard. Last issued placard #(s)_____

❑ A Replacement of my **Stolen** Hawaii placard. Last issued placard #(s)_____

❑ A Replacement of my **Confiscated/Revoked** Hawaii placard. Last issued placard #(s)_____

12. SPECIAL LICENSE PLATES REQUEST Only applicants with a disability expected to last at least 4 years may apply.

❑ I am requesting special license plates. I am (1) the registered owner of the vehicle on which the special license plates will be affixed, **AND** (2) the vehicle will be used primarily to transport me.

Year of Vehicle _____ Make _____ Model _____

Vehicle Lic. # _____ Registration Expiration Date (Month) _____ / (Year) _____

13. TERMS OF USAGE AND RELEASE OF MEDICAL INFORMATION

I declare, under the penalties of the penal law, that the statements contained herein are, to the best of my knowledge and belief, true and accurate and that I have not knowingly and willingly made a false statement or given information which I know to be false in connection therewith. I have read and understand the terms of permit usage below and I agree to abide by them. I also authorize my physician to release medical information necessary to process this application.

I understand that:

a. The permit is nontransferrable (cannot be used by anyone other than myself as the permittee). b. The placard must be visible by hanging it on the rearview mirror when in use (or placing it on the dashboard when there is no mirror). c. The placard must be removed from the rearview mirror before driving or when the placard is not in use. d. I cannot park in the access aisle (crosshatched patterned marked spaces next to a parking space reserved for persons with disabilities). e. If I park in a restricted space or area, my vehicle may be cited and towed, even when a valid parking permit is displayed. f. I must present my identification card (issued with my permit) to any enforcement officer upon request when I park in a space reserved for persons with disabilities. g. If I reported my permit as lost or stolen, it cannot be used by anyone including myself if it is found. If it is found and misused, the user will be fined.

✗_____ _____
APPLICANT'S SIGNATURE (or Authorized Representative) DATE

CERTIFICATION BY LICENSED PRACTICING PHYSICIAN

For instructions on completing this page or to obtain additional application forms, go to <www.hawaii.gov/health/dcab>.

This page must be completed by a licensed practicing physician (as defined under HRS 453, 455, 460, and 463E).

14. CERTIFICATION OF CONDITION The physician must certify that the applicant has one or more of the specific disabilities listed below (as defined under HRS §291-51). CONDITIONS THAT DO NOT QUALIFY INCLUDE, but are not limited to: blindness, deafness, upper limb amputation, mental retardation/developmental disability, infancy, old age, learning disability, and mental disability.

I certify that _____ **meets at least one of the criteria below.**
APPLICANT'S NAME

Mark appropriate box(es). Only one category is required.

(a) The applicant is **UNABLE TO WALK** 200 feet without stopping to rest due to the following condition:

❑ Arthritic ❑ Neurologic ❑ Orthopedic ❑ Oncologic ❑ Renal ❑ Vascular

(b) The applicant is diagnosed with the following **RESPIRATORY DISABILITY**:

❑ **FEV < 1L** - Forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter.

❑ **P_3O_2 < 60 mm. Hg** - Arterial oxygen tension is less than sixty mm/hg on room air at rest.

(c) The applicant is diagnosed with the following **HEART CONDITION** according to the American Heart Association Standards:

❑ **Class III** - Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity causes fatigue, palpitation, dyspnea, or anginal pain.

❑ **Class IV** - Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

(d) The applicant is **UNABLE TO WALK** without the use of, or assistance from, the following:

❑ Artificial lower limb(s) ❑ Brace(s) ❑ Crutches ❑ Walker ❑ Cane(s) (excluding white canes)

❑ Another Person ❑ Wheelchair ❑ Other Assistive Device (specify): _____

(e) ❑ The applicant **USES PORTABLE OXYGEN**.

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15. DURATION OF DISABILITY

I certify that _____ **has the physical disability as described above and is diagnosed to have a:**
APPLICANT'S NAME

❑ Long-term Disability (expected to last at least 4 years),

OR

Temporary Disability for a duration of ❑ 1 month ❑ 2 months ❑ 3 months ❑ 4 months ❑ 5 months ❑ 6 months
(Mark one box only. If the disability lasts longer than anticipated, subsequent certification can be made.)

16. NOT ABLE TO APPLY IN PERSON (Mark only if applicable)

❑ The applicant is physically unable to apply in person due to a medical condition. ✗_____
PHYSICIAN'S SIGNATURE

17. PHYSICIAN READ CAREFULLY I understand that per HRS 291, Part III, if I, as a physician, fraudulently verify that

_____ is a person with a disability (as defined in HRS §291-51) to enable
APPLICANT'S NAME

the applicant to obtain a parking permit, I shall be guilty of a petty misdemeanor, and each fraudulent verification shall constitute a separate offense. For program integrity, DCAB conducts random checks to verify the authenticity of certifications.

a. PHYSICIAN'S NAME _____ _____ _____
(Print or Type) LAST FIRST M.I.

b. MAILING ADDRESS _____ HAWAII 96_____
(Print or Type) STREET / P.O. BOX CITY STATE ZIP CODE

c. DATE _____ / _____ / _____ **d. TELEPHONE NO.** _____ **e. MEDICAL LIC. NO.** _____
MONTH DAY YEAR (HAWAII / U.S. ARMED SERVICES STATIONED IN HAWAII)

f. PHYSICIAN'S SIGNATURE ✗_____ (Circle one) **M.D.** / **N.D.** / **D.O.** / **D.P.M.**

FOR PROCESSING, APPLICANT MUST SUBMIT THIS FORM TO THE APPROPRIATE COUNTY AGENCY LISTED BELOW.
Application for initial placard and for replacement of lost, stolen, or mutilated placards must be submitted in person. Only an application for placard renewal may be conducted by mail (and must include a new physician's certification and a photo copy of identification). In addition, Oahu forms are processed at all Satellite City Halls.

HAWAII
Mayor's Office
Executive Branches
Hanama Place
Suite 103
75-5706 Kuakini Highway
Kailua-Kona, HI 96740
Phone: 329-5226

Mayor's Office
Office of Information & Complaint
25 Aupuni Street
Room 217
Hilo, HI 96720
Phone: 961-8223

KAUAI
Finance Department
Driver's License Division
4444 Rice Street
Building A
Room 480
Lihue, HI 96766
Phone: 241-6550

MAUI
Division of Motor Vehicles and Licensing
Maui Mall
70 E. Kaahumanu Avenue
Kahului, HI 96732
Phone: 270-7363

MOLOKAI
Driver Licensing Section
Public Works Building
100 Ailoa Street
Kaunakakai, HI 96748
Phone: 553-3430

LANAI
Driver Licensing Section
County Gymnasium
Fraser Avenue
Lanai City, HI 96763
Phone: 565-7878

OAHU
Department of Customer Services
Licensing and Permits
P.O. Box 30310
Honolulu, HI 96820
Or Any Satellite City Hall
Phone: 532-7710